

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04509

04506

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b 1 YEAR			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WYNELLE NURSING HOME				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Middle Last REUBEN HAMILTON BAIR				4. DATE OF DEATH Month Day Year APRIL 14 1962			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 21 - 1888		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY PERFUME CO		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN E BAIR				14. MOTHER'S MAIDEN NAME CHARLOTTE GREEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-03-5794		17. INFORMANT Address MRS CHARLES DIXON WOODSBORO MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral softening & cortical atrophy DUE TO 4-22-62 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis & left hemiplegia DUE TO 3 years (c) Arteriosclerotic cardiovascular disease 10 years							INTERVAL BETWEEN ONSET AND DEATH 3 years 3 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 12, 1962 to April 14, 1962 that (I) (we) last saw the deceased alive on 13 April 1962 and that death occurred at 6:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE James E. Stoner Jr				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 16 Apr 1962	
22c. PHYSICIAN'S NAME (Type) JAMES E. STONER, JR				22d. ADDRESS WALKERSVILLE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/17/62		23c. NAME OF CEMETERY OR CREMATORY MT HOPE		23d. LOCATION (City, town, or county) (State) WOODSBORO MD	
24. FUNERAL DIRECTOR'S SIGNATURE William E. Hartzler				ADDRESS Woodsboro, Md		25a. REC'D BY REGISTRAR DATE APR 18 '62	
				25b. REGISTRAR'S SIGNATURE William E. Hartzler			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be signed by the attending physician and completely filled out by the funeral director, or by the funeral director alone. This certificate has been signed by the attending physician and completely filled out by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01208

CERTIFICATE OF DEATH

01108

Blank certificate form with faint horizontal lines and vertical columns for data entry. The form includes fields for name, date of birth, date of death, and cause of death. There are four punch holes on the right side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04510

04507

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>8 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>FREDERICK CITY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>YADA THERESA BAKER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 26 1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY 10 1883</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>ROCKERSVILLE WASH. Co MD. U.S.A</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>OLIVER S. MULLENDORE</u>			
14. MOTHER'S MAIDEN NAME <u>FLORENCE HORNER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>JAMES A. BAKER</u> Address <u>NO. 9. N. VIRGINIA AVE. BRUNSVICK MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1</u> DUE TO <u>Anger and by</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>2nd.</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>4/18 1962</u> to <u>4/26 1962</u> , that (I) (we) last saw the deceased alive on <u>26 April 1962</u> and that death occurred at <u>4:43</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert S. Hughes</u>				M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 29 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCKERSVILLE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ROCKERSVILLE WASH. Co MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Bass</u> ADDRESS <u>BOONSBORO MD.</u>				25a. REC'D BY REGISTRAR <u>DATE MAY 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kennedy</u>	

04507

CERTIFICATE OF DEATH

04507

(M)

DATE OF DEATH

8 DAY

TIME

PLACE OF DEATH

101 N. VIRGINIA AVE

YADA

LOANER

WHITE

10-10-19

HOUSE WIFE

OWN NINE

101 N. VIRGINIA AVE

LOANER 2

LOANER

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LOANER

LOANER

04507

101 N. VIRGINIA AVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 13 Years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 728 North Market Street	
3. NAME OF DECEASED (Type or print) First ROY Middle EDGAR Last BARTHLOW		4. DATE OF DEATH Month April Day 11 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 March 1882
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Detective Agency	
11. BIRTHPLACE (County & State, or foreign country) Lewistown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Barthlow		14. MOTHER'S MAIDEN NAME Rebecca Powell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 212-24-5679	
17. INFORMANT Prearranged by Deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 6 days Several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1952 to April 11, 1962 , that (I) (we) last saw the deceased alive on April 11, 1962 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Ernest A. Dettbarn		22b. DATE SIGNED 13 April 62	
22c. PHYSICIAN'S NAME (Type) ERNEST A. DETTBARN		22d. ADDRESS Walker Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-14-62	
23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		23d. LOCATION (City, town or county) (State) Feagaville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR APR 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Evans			

01508

CITY OF CHICAGO

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Frederick

Frederick

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Frederick Memorial Hospital

Frederick Memorial Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04512
CERTIFICATE OF DEATH
04509

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Hrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 50 Carver Apts		X Rural Buckeystown	
3. NAME OF DECEASED (Type or print) Enis Virginia (Katie) First Middle Last		4. DATE OF DEATH 4 22 19 62	
5. SEX Female	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (County & State, or foreign country) Frederick, Co Md	
13. FATHER'S NAME Richard Offutt		12. CITIZEN OF WHAT COUNTRY? U.S.A	
14. MOTHER'S MAIDEN NAME Lucy English		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Lola Bowens Hall 115 Ice St, Frederick Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Ch. Auricular Fibrillation Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Arterio-sclerotic heart dis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 March 1957, to 4/22/62, that (I) (we) last saw the deceased alive on 4 April 1962, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Conley M.D.		22b. DATE SIGNED 24 Apr 62	
22c. PHYSICIAN'S NAME (Type) Dr Charles H. Conley		22d. ADDRESS Professional Bldg, Frederick, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-27-62	
23c. NAME OF CEMETERY OR CREMATORY Hopehill		23d. LOCATION (City, town or county) Frederick Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks, 111		25a. REC'D BY REGISTRAR APR 30 '62	
ADDRESS Frederick, Md		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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MAY 1962 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04510											
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN b. Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 20 West "n" Street				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 35 Brunswick d. STREET ADDRESS 20 West "n" Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Robert Lewis Campbell Jr.				4. DATE OF DEATH 4-8-62 1962				5. SEX Male 6. COLOR OR RACE Col. 7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 7-3-1929				9. AGE (In years last birthday) 32 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Construction			
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A?			
13. FATHER'S NAME Robert Lewis Campbell Sr.				14. MOTHER'S MAIDEN NAME Elsie Berry				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Mary E. Campbell, Brunswick, Maryland				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ethyl Alcohol Intoxication 880.9 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)			
19. INTERVAL BETWEEN ONSET AND DEATH 18 hrs				20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Drinking early evening to about 4:30 AM				21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
22d. INJURY OCCURRED While <input type="checkbox"/> et work Not While <input checked="" type="checkbox"/> et work				22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Brunswick				22f. (City or town) Frederick (County) Md. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE B. O. Thomas				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) B. O. Thomas				Address (Street, city, town, or county) Frederick				DATE SIGNED 4/8/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-11-62				22c. NAME OF CEMETERY OR CREMATORY Mountain			
22d. FUNERAL DIRECTOR B. H. Lutz				ADDRESS Brunswick, Maryland				22e. REC'D BY REGISTRAR APR 12 '62			
22f. REGISTRAR'S SIGNATURE Arthur S. Kline				22g. LOCATION (City, town, or county) Knoxville, Maryland				22h. (State)			

00210

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00210

THE STATE OF NEW YORK

(M)

STATE OF NEW YORK
COUNTY OF [illegible]
I, [illegible],
do hereby certify that on the [illegible] day of [illegible] A.D. 19[illegible]
at [illegible] in the County of [illegible] State of New York
I examined the body of [illegible]
and found that he/she was dead.
The cause of death was [illegible]
and the manner of death was [illegible].
I am a duly qualified and licensed Medical Examiner of the State of New York.
My commission expires on the [illegible] day of [illegible] A.D. 19[illegible].
Witness my hand and seal this [illegible] day of [illegible] A.D. 19[illegible].
[illegible]
Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04514

CERTIFICATE OF DEATH

04511

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 111 West Fifth Street		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 111 West Fifth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle AUGUSTUS Last CRAWFORD, SR.		4. DATE OF DEATH Month April Day 21 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Dec 1894
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1	11. IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	11. BIRTHPLACE (County & State, or foreign country) Feagaville, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John R. Crawford	
14. MOTHER'S MAIDEN NAME Mary C. O'Brien		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 214-10-5242		17. INFORMANT Address Walter A. Crawford, Jr., Route 5, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-genic Carcinoma rt. lung DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1962 to April 21, 1962 that (I) (we) last saw the deceased alive on April 20, 1962 and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Bernard O. Thomas, Jr. M.D.		22b. DATE SIGNED 23 Apr 1962	
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-25-62	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR APR 25 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

01511

01514

Frederick

Frederick

Frederick

Frederick

Years

Frederick

All West with friends

All West with friends

April 21, 1902

April 21, 1902

April 21, 1902

10 Dec 1902

White

White

USA

Frederick, Md.

Frederick, Md.

Frederick, Md.

July 6, 1902

John H. Newcomb

21-10-1902 Walter A. Newcomb, Jr., son of Frederick, Md.

Frederick, Md. Walter A. Newcomb, Jr.

21 Dec 1902

22 Dec 1902, Frederick, Md.

Frederick, Maryland

Frederick, Maryland

1-2-02

Frederick

April 21, 1902

Frederick, Md.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the director, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04512

1. PLACE OF DEATH e. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) • Maryland b. COUNTY Frederick		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fred'k.Co Life X Frederick, R.F.D.2 (Hopehill)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS 1		
3. NAME OF DECEASED (Type or print) Walter Franklin Diggs			4. DATE OF DEATH April 3 1962		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1899	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick County	
13. FATHER'S NAME Luther Diggs			14. MOTHER'S MAIDEN NAME Maggie Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-5863		17. INFORMANT Emma N. Diggs Address Hopehill Frederick Rt 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Hemorrhage 162 DUE TO Brochogentic Carcimomia Of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour Year +					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 5, 1962 Address (Street, city, town, or county)					
ACTUAL SIGNATURE B.O. Thomas		M.D. NAME B.O. Thomas, M.D.			
EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 4-7-62		22c. NAME OF CEMETERY OR CREMATORY Hopehill		22d. LOCATION (City, town, or country) (State) Hopehill, Fred. Co Md	
23. FUNERAL DIRECTOR C.E. Hicks, III			24a. REC'D BY REGISTRAR APR 9 '62		
ADDRESS Frederick, Md			24b. REGISTRAR'S SIGNATURE Arthur L. Hume		

MEDICAL CERTIFICATION

04812

1512



Medical Examination Certificate of Health
Name: [illegible]
Age: [illegible]
Sex: [illegible]
Date of Birth: [illegible]
Place of Birth: [illegible]
Occupation: [illegible]
Date of Examination: [illegible]
Examiner: [illegible]
Signature: [illegible]
Remarks: [illegible]

Medical Examination Certificate of Health
Name: [illegible]
Age: [illegible]
Sex: [illegible]
Date of Birth: [illegible]
Place of Birth: [illegible]
Occupation: [illegible]
Date of Examination: [illegible]
Examiner: [illegible]
Signature: [illegible]
Remarks: [illegible]

6218

CERTIFICATE OF DEATH

01513

DECEASED NAME: JAMES H. MURRAY

DATE OF DEATH: 1914

MEMORIAL HOSPITAL

WILLIAM MURRAY F. MURRAY

AGE: 47

RESIDENCE: 1111 1/2

CAUSE OF DEATH: TUBERCULOSIS

DATE OF BURIAL: 1914

BURIAL PLACE: 1111 1/2

DATE OF INTERMENT: 1914

INTERMENT PLACE: 1111 1/2

DATE OF EXHUMATION: 1914

EXHUMATION PLACE: 1111 1/2

DATE OF REINTERMENT: 1914

REINTERMENT PLACE: 1111 1/2

DATE OF REINTERMENT: 1914

REINTERMENT PLACE: 1111 1/2

DATE OF REINTERMENT: 1914

REINTERMENT PLACE: 1111 1/2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

04517

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Film G311 4/25/62 mh

CERTIFICATE OF DEATH

Reg. Dist. No.

04514

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Conn. b. COUNTY Fairfield		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont, Maryland		c. LENGTH OF STAY IN 1b 1 yr.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Canaan 45x.3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WRGH, Ft Detrick, Maryland			d. STREET ADDRESS Old Norwalk Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JONATHAN Middle NMI Last Ellsworth			4. DATE OF DEATH Month April Day 17 Year 19 62		
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 May 1962		9. AGE (In years last birthday) 19 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine		10b. KIND OF BUSINESS OR INDUSTRY Marine Corps		11. BIRTHPLACE (State or foreign country) Norwalk, Conn	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Thomas NMI Ellsworth			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 30 Sep 60-17 Apr 62			16. SOCIAL SECURITY NO. Personnel Section		
17. INFORMANT Marine Hdqtrs. 8th & I Street, Washington, D.C.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wound, gunshot (suicide) DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently from firing 45 cal. pistol		
20c. TIME OF INJURY Hour a. m. 0530 x 22 Apr 17 1962		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bldg. 24 Post Thurmont Frederick Md.	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 0530 17 Apr 19 62, to 17 April 19 62, that I last saw the deceased alive on 19, and that death occurred at 0530 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE John J. Dennehy			ADDRESS (Street, city or town, state) U.S. Army Medical Unit		
DATE SIGNED 17 Apr 62					
PHYSICIAN'S NAME (Type) JOHN J. DENNEHY, Captain, MC			Fort Detrick, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/62		22c. NAME OF CEMETERY OR CREMATORY New Canaan, Connecticut	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Funeral Home, 1400 Chapin St. NW			24a. REC'D BY REGISTRAR DATE APR 23 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

CERTIFICATE OF DEATH

FILE NO. 44

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND DATE OF DEATH: 10-15-1918		NAME OF DECEASED: [illegible]	
SEX: [illegible]		AGE: [illegible]	
PLACE OF BIRTH: [illegible]		OCCUPATION: [illegible]	
MARITAL STATUS: [illegible]		CAUSE OF DEATH: [illegible]	
DATE OF DEATH: 10-15-1918		TIME OF DEATH: [illegible]	
PLACE OF DEATH: [illegible]		NAME OF PHYSICIAN: [illegible]	
NAME OF FUNERAL HOME: [illegible]		NAME OF BURIAL PLACE: [illegible]	
NAME OF NEXT OF KIN: [illegible]		NAME OF WITNESS: [illegible]	
SIGNATURE OF DECEASED: [illegible]		SIGNATURE OF PHYSICIAN: [illegible]	
SIGNATURE OF FUNERAL HOME: [illegible]		SIGNATURE OF BURIAL PLACE: [illegible]	
SIGNATURE OF NEXT OF KIN: [illegible]		SIGNATURE OF WITNESS: [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04518

CERTIFICATE OF DEATH

04515

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 13 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont d. STREET ADDRESS E. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Margie Middle Agnes Last Finneyfrock				4. DATE OF DEATH Month April Day 13 Year 1962									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1892		9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alonza Williar						14. MOTHER'S MAIDEN NAME Jennie Wilhide							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Paul Finneyfrock Address Thurmont, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertension (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1 day										INTERVAL BETWEEN ONSET AND DEATH 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Thurmont (County) Frederick (State) Md.							
21. I certify that (I) (this hospital) attended the deceased from 12 April 1962 to 13 April 1962 , that (I) (we) last saw the deceased alive on 13 April 1962 , and that death occurred at 3:00 p.m. from the causes and on the date stated above.													
22a. SIGNATURE Robert S. Hughes M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Robert S. Hughes				22d. ADDRESS 7 E. Church St. Frederick, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-16-62		23c. NAME OF CEMETERY OR CREMATORY United Brethren Cemetery				23d. LOCATION (City, town or county) Thurmont, Md. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR APR 16 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

6513

CERTIFICATE OF DEATH

6513

Frederick

Maryland

Frederick

Frederick

13 Jan.

Thurmont

Frederick Memorial Hospital

E. Main St.

Marie Anna Kinnelbeck

April 13

65

White

April 13, 1902

On How

Maryland

U.S.A.

Alma Miller

Thurmont, Md.

Frederick Memorial Hospital

Handwritten signature

Robert S. Hughes, 7 E. Church St., Frederick, Maryland

United Brethren Cemetery

Thurmont, Md.

April 13-02

Burial

Thurmont, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04516

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Myersville d. STREET ADDRESS 7 W 3rd St Frederick e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Philip Israel Fisher		4. DATE OF DEATH Month Day Year 4 18 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/1886
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Fisher	
14. MOTHER'S MAIDEN NAME Elmira Delauter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. -		17. INFORMANT Address Daniel L. Fisher, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric ulcer DUE TO (b) gastrointestinal bleeding Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 2 1/2 days		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis generalized			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/14/62, 1962, to 4/17/62, 1962, that (I) (we) last saw the deceased alive on 4/18, 1962, and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Frank Damazo m		22b. DATE SIGNED 4/18/62	
22c. PHYSICIAN'S NAME (Type) DAMAZO FRANK		22d. ADDRESS 7 W 3rd St Frederick	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 4/21/1962	23c. NAME OF CEMETERY OR CREMATORY Luth. Cem., Church Hill, Frederick Co., Md.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		25a. REC'D BY REGISTRAR APR 23 '62	
25b. REGISTRAR'S SIGNATURE Wm. S. Harris			

1871

04516

Frederick

Hampden

Frederick

Frederick

5 days

Frederick

Frederick Memorial Hospital

Frederick

Frederick

Frederick

Frederick

Frederick

Male

White

1871

75

Carpenter

Building contract, Maryland

U.S.

George Fisher

Elmer Deaton

James I. Fisher, Frederick, Md.

Frederick Memorial Hospital

Frederick Memorial Hospital

X

Frank & Company
CHAMASO & FRANK
713 3rd St. Frederick

Frederick Memorial Hospital
Frederick, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, it may be retained by the hospital or attending physician. If the death occurs in a hospital, it may be retained by the hospital or attending physician. If the death occurs in a nursing home, it may be retained by the nursing home or attending physician. If the death occurs in a funeral home, it may be retained by the funeral home or attending physician. If the death occurs in a mortuary, it may be retained by the mortuary or attending physician. If the death occurs in a cemetery, it may be retained by the cemetery or attending physician. If the death occurs in a place of public accommodation, it may be retained by the place of public accommodation or attending physician. If the death occurs in a place of business, it may be retained by the place of business or attending physician. If the death occurs in a place of worship, it may be retained by the place of worship or attending physician. If the death occurs in a place of education, it may be retained by the place of education or attending physician. If the death occurs in a place of recreation, it may be retained by the place of recreation or attending physician. If the death occurs in a place of transportation, it may be retained by the place of transportation or attending physician. If the death occurs in a place of government, it may be retained by the place of government or attending physician. If the death occurs in a place of industry, it may be retained by the place of industry or attending physician. If the death occurs in a place of commerce, it may be retained by the place of commerce or attending physician. If the death occurs in a place of finance, it may be retained by the place of finance or attending physician. If the death occurs in a place of science, it may be retained by the place of science or attending physician. If the death occurs in a place of art, it may be retained by the place of art or attending physician. If the death occurs in a place of culture, it may be retained by the place of culture or attending physician. If the death occurs in a place of religion, it may be retained by the place of religion or attending physician. If the death occurs in a place of philosophy, it may be retained by the place of philosophy or attending physician. If the death occurs in a place of literature, it may be retained by the place of literature or attending physician. If the death occurs in a place of history, it may be retained by the place of history or attending physician. If the death occurs in a place of geography, it may be retained by the place of geography or attending physician. If the death occurs in a place of politics, it may be retained by the place of politics or attending physician. If the death occurs in a place of law, it may be retained by the place of law or attending physician. If the death occurs in a place of medicine, it may be retained by the place of medicine or attending physician. If the death occurs in a place of health, it may be retained by the place of health or attending physician. If the death occurs in a place of education, it may be retained by the place of education or attending physician. If the death occurs in a place of recreation, it may be retained by the place of recreation or attending physician. If the death occurs in a place of transportation, it may be retained by the place of transportation or attending physician. If the death occurs in a place of government, it may be retained by the place of government or attending physician. If the death occurs in a place of industry, it may be retained by the place of industry or attending physician. If the death occurs in a place of commerce, it may be retained by the place of commerce or attending physician. If the death occurs in a place of finance, it may be retained by the place of finance or attending physician. If the death occurs in a place of science, it may be retained by the place of science or attending physician. If the death occurs in a place of art, it may be retained by the place of art or attending physician. If the death occurs in a place of culture, it may be retained by the place of culture or attending physician. If the death occurs in a place of religion, it may be retained by the place of religion or attending physician. If the death occurs in a place of philosophy, it may be retained by the place of philosophy or attending physician. If the death occurs in a place of literature, it may be retained by the place of literature or attending physician. If the death occurs in a place of history, it may be retained by the place of history or attending physician. If the death occurs in a place of geography, it may be retained by the place of geography or attending physician. If the death occurs in a place of politics, it may be retained by the place of politics or attending physician. If the death occurs in a place of law, it may be retained by the place of law or attending physician. If the death occurs in a place of medicine, it may be retained by the place of medicine or attending physician. If the death occurs in a place of health, it may be retained by the place of health or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04520 CERTIFICATE OF DEATH 04517

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN b. 4 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Jefferson d. STREET ADDRESS 1 a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle CORDELIA Last FRY		4. DATE OF DEATH Month April Day 28 Year 19 62					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Feb 1874	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Jefferson, Maryland			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Rhoderick		14. MOTHER'S MAIDEN NAME Cordelia Jane Boyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Eleanor M. Culler			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Probable Acute myocardial infarction with acute pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arterio-sclerotic heart dis. (c) Cholecystectomy 11 April 1962		INTERVAL BETWEEN ONSET AND DEATH 1 hour Prior to 1957		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1957 to 28 April 1962 that (I) (we) last saw the deceased alive on 28 April 1962 and that death occurred at 10:35 P. from the causes and on the date stated above.							
22a. SIGNATURE Charles H Conley, Jr. M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 30 Apr 1962			
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-62		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery			
23d. LOCATION (City, town or county) (State) Jefferson, Md.		23e. REC'D BY REGISTRAR MAY 3 '62		23f. REGISTRAR'S SIGNATURE Arthur L. Hume			
24. FUNERAL DIRECTOR'S NAME (Type) M. R. Etchison & Son, Frederick, Maryland		24a. ADDRESS Frederick, Maryland					

(M)

04520

04517

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick Memorial Hospital

WHITE

QUINCY

WHITE

WHITE

WHITE

Female

White

1 FEB 1874

UP

House-work

At home

Delaware, Maryland

Joseph Frederick

Delaware name cover

No

Home

Mr. Eleanor M. Guller, Washington, D. C.

(1)



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928

CONFIDENTIAL

Mr. J. H. Jones

OK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

04522

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04519

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Cora Middle Miller Last Garrett		4. DATE OF DEATH Month 4 Day 13 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-1874
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months 8 Days 13 Hours 13 Min. 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Barton Van Buren		14. MOTHER'S MAIDEN NAME Lydia Atkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Miss Virginia Garrett, Thurmont, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 4500 DUE TO Coronary heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis DUE TO 3. No PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 April 1962 to 13 April 1962 , that I last saw the deceased alive on 12 April 1962 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Maryland DATE SIGNED Robert S. Hughes			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-62	
22c. NAME OF CEMETERY OR CREMATORY Saint Marks		22d. LOCATION (City, town, or county) (State) Petersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Felt		24a. REC'D BY REGISTRAR APR 19 1962	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
04523 CERTIFICATE OF DEATH 04520													
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville c. LENGTH OF STAY IN 1b 16 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville d. STREET ADDRESS a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Florence Middle J. Last Gaver						4. DATE OF DEATH Month 4 Day 24 Year 1962							
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/11/1895		9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) W. Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William Jones						14. MOTHER'S MAIDEN NAME Mary Jane Ellis							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) no				16. SOCIAL SECURITY NO. 213-24-7801		17. INFORMANT Lloyd F. Gaver, Myersville, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1: Multiple Myeloma 2: Diabetes Mellitus												INTERVAL BETWEEN ONSET AND DEATH 7 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (XXXXXX) attended the deceased from Nov. 19 55 to April 62 , that (I) (we) saw the deceased alive on April 24 62 and that death occurred at 1:30 A.M. from the causes and on the date stated above.													
22a. SIGNATURE Leo J. Gaver M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) Leo J. Gaver, M.D.						22d. ADDRESS Mallow Hill Ave., Baltimore 29, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/27/1962		23c. NAME OF CEMETERY OR CREMATORY U.B. Cemetery				23d. LOCATION (City, town or county) (State) Myersville, Md.					
24 FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.						ADDRESS		25a. REC'D BY REGISTRAR APR 26 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Nune			

04523

04520

Frederick

James L. Davis

James L. Davis

Female

Female

Housewife

W. Virginia

William Jones

Harry James Ellis

013-2-9801

James L. Davis, Maryland, Md.

Frederick County, Maryland

Frederick County, Maryland

April 24

April 24

Leo J. Davis, M.D.

Frederick County, Md.

Frederick County, Md.

Frederick County, Md.

Frederick County, Md.

Frederick County, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: Any death certificate must be signed by the attending physician and completely filled in before the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04524

04521

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mountaineale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 7th Ave.				d. STREET ADDRESS 104 7th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Manzella Middle Virginia Last Gray				4. DATE OF DEATH Month April Day 2 Year 19 62			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1871		9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli D. Rice				14. MOTHER'S MAIDEN NAME Rosanna Rogers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Earl M. Weddle Brunswick, Md. 104 7 Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 434 DUE TO Candidians, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Decompensated Congestive Heart Failure DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hours 6 mon.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 25 , 19 62 , to April 2 , 19 62 , that I last saw the deceased alive on April 2 , 19 62 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gum Spring Hollow DATE SIGNED April 2, 1962 ACTUAL SIGNATURE C.T. Byron Kao M.D. PHYSICIAN'S NAME (Type) C.T. Byron Kao, M.D. Brunswick, Maryland							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 4-5-62		22c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery		22d. LOCATION (City, town, or county) (State) Lewistown Md. Fred. Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Greager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE APR 5 '62	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE BOARD OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
04525				CERTIFICATE OF DEATH				04522			
Item 8, 9, 11m (31) 4/23/62 mh											
1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL (LIMERIKIN)</u>				c. LENGTH OF STAY IN 1b <u>42 yr</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL (LIMERIKIN)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT # 2</u>				d. STREET ADDRESS <u>RT # 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JESSE</u> Middle <u>B</u> Last <u>GROVE</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>8</u> Year <u>1962</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>EDW. BOWLUS</u>				14. MOTHER'S MAIDEN NAME <u>MARY CHAGGETTE</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS FRANCIS SAPPINGTON</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>10 yrs +</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/20</u> 19 <u>50</u> , to <u>4/8</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>62</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Henry V. Chase</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/9/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				22d. ADDRESS <u>4 E. Church St Frederick Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>4/11/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence C. Garty</u>				ADDRESS <u>Frederick Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

01332

CERTIFICATE OF DEATH

01332

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04526
04523

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRUNSWICK</u> c. LENGTH OF STAY IN 1b <u>30 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EAST C. STREET</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRUNSVVIC</u> d. STREET ADDRESS <u>EAST C. STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BERTHA C. HARRISON</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>20</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 12, 1910</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>YARROWSBURG WASH. CO MD. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>ALONZA PHILLIPS</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE HIMES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>WILLIAM HARRISON</u>				Address <u>BRUNSVIC MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 260X } DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Arteriosclerotic Disease</u> (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>8 yrs.</u> <u>8 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> e.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 19, 1962</u> to <u>April 20, 1962</u> that (I) (we) last saw the deceased alive on <u>April 20, 1962</u> , and that death occurred at <u>4:15 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>C. T. Byron Kao</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-21-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. T. Byron Kao</u>				22d. ADDRESS <u>Gum Spring Hollow, Brunswick, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR. 23, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BROWNSVILLE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BROWNSVILLE WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				ADDRESS <u>BOONSBORO MD</u>		25a. REC'D BY REGISTRAR <u>APR 25 '62</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MDR KAO

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04338

CERTIFICATE OF DEATH

04338

NAME OF DECEASED: [illegible]
AGE: [illegible] YEARS
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESS: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF MINISTER: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04524

1. PLACE OF DEATH e. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Damascus</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS <i>15X-2</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Clara S. Hawkins</i>		4. DATE OF DEATH Month Day Year <i>April 20 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>November 4, 1889</i>
9. AGE (in years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Nathan Snyder</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Mills</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <i>Algia Hawkins, Damascus Md</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Atherosclerosis</i> (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Month, Day, Year Hour e.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4/7</i> <i>1962</i> to <i>4/20</i> <i>1962</i> , that (I) (we) last saw the deceased alive on <i>4/20</i> <i>1962</i> , and that death occurred at <i>1:15</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>A. A. Pearre</i> M.D.		22b. DATE SIGNED <i>4/20/62</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>4 E. Church St., Frederick, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>4/23/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>	23d. LOCATION (City, town or county) (State) <i>Beallsville Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest E. Lathrop</i> ADDRESS <i>Faithsburg Md</i>		25a. REC'D BY REGISTRAR <i>APR 24 '62</i>	25b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1252

04552

Frederick Maryland Frederick

Route 2 30 miles - Westville

Route 2 30 miles - Westville

EDNA WASH KANSAS APRIL 20 62

Female white May 10, 1922 62

own home Frederick Co. Md. U.S.A.

Robert Wolf Laura Kohn

name T. Anita Kohn, Westville, Md. 20.2

*Copy from
Robert Wolf's
file paper 22 pages*

U. S. Army Camp Middlestown, Md.

April 22, 1922 St. Ann's Lutheran Westville, Md.

Local P. M. Little, Westville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be delayed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04529
04526

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont c. LENGTH OF STAY IN 1b 6 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Own Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont d. STREET ADDRESS e. Main St.. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle J. Last Lambert		4. DATE OF DEATH Month April Day 4 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1870
9. AGE (In years and birthday) 91 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James H. Joy	
14. MOTHER'S MAIDEN NAME Rosanna Measell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ross Firor Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease Arteriosclerotic type 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) and DUE TO (c) Terminal general exhaustion		INTERVAL BETWEEN ONSET AND DEATH 4 mos 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour no e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 19 1961 to Apr. 4 1962 that (I) (we) last saw the deceased alive on Apr. 3 1962 and that death occurred at PM , from the causes and on the date stated above.			
22a. SIGNATURE James K. Gray		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-7-62	
23c. NAME OF CEMETERY OR CREMATORY Middletown Refm. Cem.		23d. LOCATION (City, town or county) (State) Middletown Fred. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		25a. REC'D BY REGISTRAR DATE APR 9 '62	
ADDRESS Thurmont, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

(M)

(I)

Thurmond
Frederick

Own Home

Corra J.

Female White

Housewife

James R. Joy

No

None

6 years

Hambers

Thurmond

W. Main St.

April 11

March 10, 1917

Maryland

Roanna Hensell

Mrs. Rosa Victor Thurmond, Md.

James R. Joy

Thurmond, Maryland

4-7-25

Washington, D.C.

1115 Jackson Road, Co. Md.

Thurmond, Maryland

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04530

04527

1. PLACE OF DEATH e. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Lewis Filling Sta. Main & Church				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont d. STREET ADDRESS Summit Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) PAUL J. McCloskey		4. DATE OF DEATH Month April Day 21 Year 1962		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19-1917		9. AGE (In years birthday) 44 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Wholesale Grocery				11. BIRTHPLACE (County & State, or foreign country) Pittsburgh Pa				12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Paul M. Little Sr.				14. MOTHER'S MAIDEN NAME Agnes L. Tayman				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. II				16. SOCIAL SECURITY NO. 579-18-3394				17. INFORMANT Address Paul Little III Thurmont. Md			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Arteriosclerotic cardiovascular disease DUE TO (b) 5 years DUE TO (c) Interval between onset and death PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) History 3 previous coronarys																			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1957 to 1962, 1962, 1962, that (I) (we) last saw the deceased alive on 1962-19, and that death occurred at 1962-19, from the causes and on the date stated above.																			
22a. SIGNATURE Thomas A. Love								22b. DATE SIGNED 4/23/62				22c. PHYSICIAN'S NAME (Type) Thomas A. Love				22d. ADDRESS 14 W. Main St. Thurmont Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/24/62				23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem.				23d. LOCATION (City, town or county) (State) Thurmont MD							
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager								25a. REC'D BY REGISTRAR DATE APR 24 '62				25b. REGISTRAR'S SIGNATURE William S. Thomas							

04553

CERTIFICATE OF DEATH

04553



Frederick

Frederick

Frederick

Lewis, William, son of Lewis, William, and Lewis, Mary

born 11-11-1911, died 11-11-1911, age 0 years, 0 months, 0 days

cause of death: unknown

buried in the cemetery of the Lutheran Church, St. Louis, Mo.

signed and sealed this 11th day of November, 1911

Paul M. Dwyer, M.D.

Witness my hand and seal this 11th day of November, 1911

Carroll-Kimberly

Witness my hand and seal this 11th day of November, 1911

Witness my hand and seal this 11th day of November, 1911

Paul M. Dwyer, M.D.

Witness my hand and seal this 11th day of November, 1911

04553

04553

04553

04553

TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. The 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04531

04528

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 19 South Maple Avenue			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick d. STREET ADDRESS 1 Petersville Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Grace Middle Irene Last Mathews			4. DATE OF DEATH Month 4 Day 22 Year 19 62		
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2-8-1886 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas E. Dean 14. MOTHER'S MAIDEN NAME Mary Oden					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 4-22-62 17. INFORMANT Jessie Mathews, Brunswick, Maryland Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral - section DUE TO (b) 154 X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4-20- 20f. (City or town) 4-22-62 (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4-20- 19 62 to 4-22-62 , that (I) (we) last saw the deceased alive on 4-22-62 , and that death occurred at 4 P.M. from the causes and on the date stated above.					
22a. SIGNATURE C. E. PRUITT M.D. 22b. DATE SIGNED 4-24-62 22c. PHYSICIAN'S NAME (Type) C. E. PRUITT 22d. ADDRESS BRUNSWICK, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-25-62 23c. NAME OF CEMETERY OR CREMATORY Saint Lukes ADDRESS Brunswick, Maryland 23d. LOCATION (City, town or county) Point of Rocks, Md (State)					
24. FUNERAL DIRECTOR'S SIGNATURE B. H. Felt			25a. REC'D BY REGISTRAR APR 26 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Felt		

01328

01328


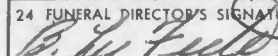
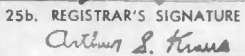
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[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04532 CERTIFICATE OF DEATH 04529

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS 208 "A" Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida Louise Mathias		4. DATE OF DEATH Month 4 Day 16 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1877
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 4 Days 16	11. IF UNDER 24 HRS. Hours 16 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME -Sauers	
14. MOTHER'S MAIDEN NAME Do not know		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Polendus Mathias, Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Nephroses DUE TO (c) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr. 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 14, 1962 to April 16, 1962 that (I) (we) last saw the deceased alive on April 16, 1962 and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE  M.D.		22b. DATE 4-18-62	
22c. PHYSICIAN'S NAME (Type) C.T. Byron Kao, M.D.		22d. ADDRESS Gum Spring Hollow, Brunswick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-19-62	23c. NAME OF CEMETERY OR CREMATORY Louden Park	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE  B. H. Fuld Brunswick, Maryland		25a. REC'D BY REGISTRAR APR 23 '62 DATE	
25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. The 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04533 CERTIFICATE OF DEATH 04530

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Frederick Memorial</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>28 Carver Apt</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Ann</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-1891</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co, Md</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13. FATHER'S NAME <u>Levin Leakins</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Ann Gassoway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) <u>* * * * *</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Anna Mary Ambush</u> Address <u>Frederick, Md 243 Center St</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERNICIOUS ANEMIA- untreated, severe</u> DUE TO <u>290.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CEREBRAL THROMBOSIS</u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>4/4</u> to <u>4/6</u>, 19<u>62</u> that (1) (we) last saw the deceased alive on <u>4/6</u>, 19<u>62</u>, and that death occurred at <u>10:4</u> A.M. from the causes and on the date stated above.			
22e. SIGNATURE <u>Richard C. Reynolds,</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>Dr Richard C. Reynolds</u>		22d. ADDRESS <u>9 E. Church Frederick, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-9-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	23d. LOCATION (City, town or county) (State) <u>Frederick Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks, lll</u>		ADDRESS <u>Frederick, Md</u>	
25a. REC'D BY REGISTRAR <u>APR 9 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

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TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filled in by the funeral director. Then please remove carbon pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filled in by the funeral director. Then please remove carbon pages 3 and 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04534

CERTIFICATE OF DEATH

04531

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Mount Airy d. STREET ADDRESS R. D. 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE P. NAILL		4. DATE OF DEATH Month April Day 4 Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1892
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Uriah Nail		14. MOTHER'S MAIDEN NAME Mary Reaver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-0466	
17. INFORMANT Mrs. Myrtle E. Nail, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Coronary atherosclerosis DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour e.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 22 April 1962 to 4 April 1962 that (I) (we) last saw the deceased alive on 3 April 1962 and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert S. Hughes M.D.		22b. DATE SIGNED APR 6 '62	
22c. PHYSICIAN'S NAME (Type) Robert S. Hughes, M. D.		22d. ADDRESS Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 7, 1962	23c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Box 241, Sykesville, Md.		25a. REC'D BY REGISTRAR DATE APR 6 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04535

CERTIFICATE OF DEATH

04532

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights c. LENGTH OF STAY IN 1b Since 5/19/60 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Vindobona Convalescent & Rest Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAISIE ALICE RANNEBERGER		4. DATE OF DEATH Month April Day 18 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Aug 1877
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 45 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles F. Oland		14. MOTHER'S MAIDEN NAME Clara Craver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert M. Ranneberger		Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile Asthenia DUE TO Generalized Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.0 (b) Generalized Arterio-sclerosis (c) Generalized Arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1946 to 18 Apr 1962 , that (I) (we) last saw the deceased alive on 2 Apr 1962 , and that death occurred 8:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Conley, Jr. M.D.		22b. DATE SIGNED 19 Apr 1962	
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-21-62	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Frank R. Smith Jr. M. R. Etchison & Son, Frederick, Maryland		25. REC'D BY REGISTRAR APR 23 '62 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the attending physician and completed and filed in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04534
CERTIFICATE OF DEATH

04534

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 46 Years		d. STREET ADDRESS 106 West Third Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SOPHIE Middle JULIANNA Last REICH		4. DATE OF DEATH Month April Day 21 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Feb 1885
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Private Duty	11. BIRTHPLACE (County & State, or foreign country) Frederick County Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Isaac S. Reich		14. MOTHER'S MAIDEN NAME Annie Zimmerman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Prearranged by deceased
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Bilateral hydronephrosis DUE TO (c) Left Pyonephrosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 days. ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arterio-sclerotic Heart Dis. + Overexpansion of Aorta		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 51
20f. (City or town) Frederick		(County) Frederick	
(State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from 1951 to 4/21/62, that (I) (we) last saw the deceased alive on 4/21/62, and that death occurred at 1:50 PM, from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Conley, Jr. M.D.		22b. DATE SIGNED 23 Apr 1962	
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M. D.		22d. ADDRESS 228 N. Market St., Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-24-62	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR APR 25 1962	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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Frederick Memorial Hospital

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Frederick Memorial Hospital

Wm. L. Brown

VR A15 (4)
15M 9/60

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Frederick

Maryland

Frederick

Jefferson-Maryland

22 years

Jefferson-Maryland

John Jefferson

John Jefferson

(Also known as Frederick Nelson Harrison)

April 12, 1870

Frederick, Maryland

VI

15 June 1870

Wife

Male

John

Frederick, Md.

John Harrison

Frederick

Mary Alice Rice

Frederick, Maryland

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113-18-252 Mrs. J. A. Harrison (born as Rice)

no

Frederick, Maryland

10 Aug 1908

130 N. Market St., Frederick, Md.

Box R. Martin, N. D.

Frederick, Md.

Frederick, Md.

1-1-02

Frederick

Frederick & Son, Frederick, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04538 CERTIFICATE OF DEATH 04535											
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN 1b 35 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 16 North Virginia Avenue						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS 16 North Virginia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Clarence D. Showbridge						4. DATE OF DEATH Month 4 Day 20 Year 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-1872		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 4 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telegrapher B.&O.R.R.Co						10b. KIND OF BUSINESS OR INDUSTRY West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Showbridge						14. MOTHER'S MAIDEN NAME Mary Hood					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Geraldine Jones, Brunswick, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/14 19 62 to 4/20 19 62 that (I) (we) last saw the deceased alive on 4/20 19 62 and that death occurred at 10:50 a.m. from the causes and on the date stated above.			
22a. SIGNATURE W.B. Carpenter M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/21/62			
22c. PHYSICIAN'S NAME (Type) Brunswick, Md.						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-1962		23c. NAME OF CEMETERY OR CREMATORY Harper		23d. LOCATION (City, town or county) (State) Harpers Ferry, West Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE B. H. Hult ADDRESS Brunswick, Maryland						25a. REC'D BY REGISTRAR DATE APR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2628

14

070

W. J. P. A. W.

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

1930

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Signature of informant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04540
04537
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN 1b 35 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 124 9th Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS 124 9th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alma Lorena Smith				4. DATE OF DEATH Month 4 Day 24 Year 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1873	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Jashua Day				14. MOTHER'S MAIDEN NAME Laura Day			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lee Smith, Brunswick, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/18/62 to 4/24/62 , that (I) (we) last saw the deceased alive on 4/18/62 and that death occurred at 8 A.M. from the causes and on the date stated above.							
22a. SIGNATURE J.G.F. Smith				22b. ADDRESS Brunswick, Maryland		22c. DATE SIGNED 4/26/62	
22c. PHYSICIAN NAME (Type) J.G.F. Smith		22d. ADDRESS Brunswick, Maryland		22e. REC'D BY REGISTRAR APR 30 '62		22f. REGISTRAR'S SIGNATURE Arthur L. Hines	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-62		23c. NAME OF CEMETERY OR CREMATORY Saint Marks		23d. LOCATION (City, town or county) (State) Petersville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE B. M. Felt ADDRESS Brunswick, Maryland				25a. REC'D BY REGISTRAR APR 30 '62			

04537

CERTIFICATE OF DEATH

04537

I, _____

Signature

Handwritten text

Handwritten signature

I, _____

04537

I, _____

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04541

04538

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 16 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 308 Adam Road				d. STREET ADDRESS 308 Adam Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle D. Last Snider				4. DATE OF DEATH Month April Day 27 Year 19 62			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 5-1926		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Clarence M. Snider				14. MOTHER'S MAIDEN NAME Bessie Neal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 196-11-3840		17. INFORMANT Mrs. James D. Snider-308 Adam Rd.-Frederick-Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary thrombosis DUE TO (b) coronary arterio sclerosis DUE TO (c) 1 1/2 yrs.							INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/16 1961 to 4/27 1962 that (I) (we) last saw the deceased alive on 4/27 1962 and that death occurred at 4/27 1962 M, from the causes and on the date stated above.							
22a. SIGNATURE L. R. Schoolman				22b. DATE SIGNED 4/28/62		22c. PHYSICIAN'S NAME (Type) L.R. Schoolman	
22d. ADDRESS 810 Toll House Ave.-Frederick-Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-30-1962		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick- Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Dailey's Funeral Home-Frederick-Maryland				25a. REC'D BY REGISTRAR MAY 1 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10 years

back mba 80F

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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Introduction

Penalty points

A.E.U.

James M. Smith

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II. 2000 Yr.

018-11-201

Mr. James D. Baker, 501 Adam St., Frederick, Md.

1.8 School Year

810 Telf House Ave - Chicago - IL

Conclusions

9801-07-1

10. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 10, 1205-1212.

Frederick - 10/1/67

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04540

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the date of the death in the space provided. This certificate is to be filed with the State Board of Health. Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN b. 21 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 239 West Patrick Street				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 239 West Patrick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Richard Edgar Snyder, Jr. First Middle Last 4. DATE OF DEATH April 16, 1962 Month Day Year							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 3-15-1941 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 21 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 11. BIRTHPLACE (State or foreign country) Frederick, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Edgar Snyder, Sr.				14. MOTHER'S MAIDEN NAME Anna L. Shafer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. Richard E. Snyder, Sr. Frederick, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO 744.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Muscular Dystrophy DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 3-4 days 21 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>B. O. Thomas</i> EXAMINER'S NAME (Type) Dr. B. O. Thomas, Sr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-17-1962			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-1962		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or country) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR <i>Robert E. Dailey & Son</i> ADDRESS Frederick, Maryland				24a. REC'D BY REGISTRAR APR 18 1962 DATE			
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>							

Frederick	Frederick	Frederick	Frederick
SI years	SI years	SI years	SI years
333 West Patrick Street	333 West Patrick Street	333 West Patrick Street	333 West Patrick Street
April 16, 1968	April 16, 1968	April 16, 1968	April 16, 1968
SI	SI	SI	SI
U.S.A.	U.S.A.	U.S.A.	U.S.A.
None	None	None	None
Richard Edgar Snyder, Sr.	Richard Edgar Snyder, Sr.	Richard Edgar Snyder, Sr.	Richard Edgar Snyder, Sr.
None	None	None	None
Mr. Richard E. Snyder, Jr. Frederick, Maryland	Mr. Richard E. Snyder, Jr. Frederick, Maryland	Mr. Richard E. Snyder, Jr. Frederick, Maryland	Mr. Richard E. Snyder, Jr. Frederick, Maryland
3-4 days	3-4 days	3-4 days	3-4 days
SI years	SI years	SI years	SI years

1-17-1968	1-17-1968	1-17-1968	1-17-1968
Frederick, Maryland	Frederick, Maryland	Frederick, Maryland	Frederick, Maryland
Mr. Oliver Gansberg	Mr. Oliver Gansberg	Mr. Oliver Gansberg	Mr. Oliver Gansberg
1-19-1968	1-19-1968	1-19-1968	1-19-1968
Robert L. Baker & Son	Robert L. Baker & Son	Robert L. Baker & Son	Robert L. Baker & Son
Frederick, Maryland	Frederick, Maryland	Frederick, Maryland	Frederick, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04544 CERTIFICATE OF DEATH 04541

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 3 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 600 Taney Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 600 Taney Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE MARGUERITE SPENCER		4. DATE OF DEATH Month April Day 10 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Nov 1901
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Ladiesburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel D. Schwarber		14. MOTHER'S MAIDEN NAME Margaret J. Rowe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Vernon H. Spencer (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal failure 153.4 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Carcinoma of bowel & metastases (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from March 1962 to April 1962 , that (I) (we) last saw the deceased alive on 10 April 1962 , and that death occurred at 4 P , from the causes and on the date stated above.		22a. SIGNATURE J. R. Poirer M.D. 22b. DATE SIGNED 12 Apr 1962 22c. PHYSICIAN'S NAME (Type) J. R. Poirer, M. D. 22d. ADDRESS Frederick Medical Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-13-62	
23c. NAME OF CEMETERY OR CREMATORY Union Chapel Cemetery		23d. LOCATION (City, town or county) (State) Near Libertytown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		25a. REC'D BY REGISTRAR APR 16 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04542

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 60 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Monocacy Hall Nursing				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 301 West Fifth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CATHERINE PHILABENA STALEY				4. DATE OF DEATH April 4, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Feb 1875	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Conrad Brust				14. MOTHER'S MAIDEN NAME Louisa Sandmyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-4641A		17. INFORMANT August T. Brust, Sr. (Same as item #2)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Chronic Congestive failure DUE TO (c) Arterio-sclerotic heart dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 mos. 10+yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
21. TIME OF INJURY Hour a.m. p.m. 19		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 Oct 1961 to 4/4/62 , 1962, that (I) (we) last saw the deceased alive on 2 April 1962 and that death occurred at 6:15A M, from the causes and on the date stated above.							
22a. SIGNATURE Charles H. Conley, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4 Apr 1962	
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M. D.				22d. ADDRESS 228 N. Market St., Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-62		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25e. REC'D BY REGISTRAR APR 9 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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01512

01512

Frederick

Frederick

Frederick

Frederick

Frederick Hall Building

Frederick Hall Building

Frederick

Frederick

Frederick

Frederick

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04543

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 267 Dill Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First EMMA Middle GRACE Last STALEY				4. DATE OF DEATH Month April Day 22 , Year 1962											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 Sept 1892		9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 9		11. IF UNDER 24 HRS. Hours 14 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (County & State, or foreign country) Carroll County Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles W. Dorcus						14. MOTHER'S MAIDEN NAME Emma Feiser									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-36-2605				17. INFORMANT Irving E. Staley (Same as item #2)				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 DUE TO Myocardial infarction Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 14 days												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 21 April 1962 to 22 April 1962 that (I) (we) last saw the deceased alive on 22 April 1962 and that death occurred at 5:05 P.M. from the causes and on the date stated above.															
22e. SIGNATURE Robert S. Hughes M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 23 Apr 1962					
22c. PHYSICIAN'S NAME (Type) Robert S. Hughes, M. D.						22d. ADDRESS 7 E. Church St., Frederick, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-25-62				23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery				23d. LOCATION (City, town or county) (State) Frederick, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland						25a. REC'D BY REGISTRAR APR 26 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Hines					

04543

04543



Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

307 Hill Avenue

Frederick Memorial Hospital

April 22, 1943

STANLEY

GRADE

GRADE

69

10 30th 1943

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1943

Frederick County Maryland

Frederick County Maryland

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Frederick County Maryland

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23 Nov 1943

Frederick County Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04547 CERTIFICATE OF DEATH 04544

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Braddock Heights d. STREET ADDRESS 112 Maryland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Edwin Ernst Stoffer				4. DATE OF DEATH Month Day Year April 18 19 62											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 9, 1889		9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Stoffer Ins. Agency				11. BIRTHPLACE (County & State, or foreign country) Theresa, Wisconsin.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Carl Stoffer						14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W.# 1 105-05-1318		17. INFORMANT Address Jennie C. Stoffer, 112 Maryland Ave, Braddock, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) mesenteric artery occlusion with gangrene of small bowel 24 hrs DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from 4/17 to 4/18 , 19 62 , that (I) (we) last saw the deceased alive on 4/18 , 19 62 , and that death occurred at 3:45 A.M., from the causes and on the date stated above.															
22a. SIGNATURE Frank Dampp M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/18/62							
22c. PHYSICIAN'S NAME (Type) DAMPAZO FRANK						22d. ADDRESS 7 W 3rd Frederick									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/21/1962		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery				23d. LOCATION (City, town or county) Frederick		(State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland.						25a. REC'D BY REGISTRAR DATE APR 23 '62		25b. REGISTRAR'S SIGNATURE C. J. L. Hanks							

04514

CERTIFICATE OF DEATH

04514

Residence

Address

Age

Occupation

Married

Single

Widow

112 1/2 Main Ave.

Frederick Hospital

Doctor

Physician

Health

January 2, 1903

White

Male

U.S.A.

Frederick, Maryland

Native

Death

Card of Death

102-5-110 Female, Doctor, 112 1/2 Main Ave., Frederick, Md.

Age 41

*Prostatectomy and perineal
with prostatic abscess*

Generalized arteriosclerosis

4/17 4/18 4/19

*Frank Thompson M.D.
DANAS Frank 700 3rd Frederick*

Frederick, Maryland

... on death, Frederick, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be filed with the hospital or attending physician. The law also requires that the death certificate be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04548 CERTIFICATE OF DEATH 04545

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick -Rural d. STREET ADDRESS Nr. Adamstown e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DOUGLAS Howard STUP		4. DATE OF DEATH Month Day Year April 14 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1960
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days 2	IF UNDER 24 HRS. Hours Min. 10 min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Howard J. Stup, Jr.	
14. MOTHER'S MAIDEN NAME Texanna Belle Wood		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Howard J. Stup, Jr. Route #4, Frederick, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO Conditions, if any, which gave rise to immediate cause (b) ASPIRATION ESOPHAGEAL CONTENTS (a), stating the underlying cause last. (c) TRACHEO-ESOPHAGEAL FISTULA - REPAIRED PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 mos.		INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 min. 2 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 to 14 APRIL , 19 62 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE F. J. Helorich M.D. 22c. PHYSICIAN'S NAME (Type) F. J. HELORICH		22b. DATE SIGNED 14 April 62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS FREDERICK, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 17, 1962	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick Maryland.
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland.		25a. REC'D BY REGISTRAR DATE APR 18 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

04542

CERTIFICATE OF DEATH

1942

Robertson

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Robertson - Mrs.

Robertson

Robertson

Robertson Memorial Home

April 1942

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
04549										
04546										
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville			c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) MILTON V. SUMMERS					4. DATE OF DEATH Month April Day 5 Year 1962					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24, 1878		9. AGE (In years last birthday) 83 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY own Gen. Farm		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Joshua Summers					14. MOTHER'S MAIDEN NAME Mary Leatherman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Nannie Summers, Myersville, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH Minutes years.										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 4-5 62		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1958 to 4-5 62 , that (I) (we) last saw the deceased alive on 4-5 62 , and that death occurred at 4-5 62 AM, from the causes and on the date stated above.										
22a. SIGNATURE D. J. Boyer M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-6-62			
22c. PHYSICIAN'S NAME (Type) D. J. BOYER M.D.					22d. ADDRESS 135 No. Pot. St. HAG. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 7, 1962		23c. NAME OF CEMETERY OR CREMATORY United Brethern		23d. LOCATION (City, town or county) (State) Myersville, Fred. Co. Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle					ADDRESS Paul F. Bittle, Myersville, Md.		25a. REC'D BY REGISTRAR APR 9 '62		25b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

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SUMMERS

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Nov. 24, 1918

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retired farmer

own farm, Fred. Co. Md.

John Summers

Myersville

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Myersville, Md.

Handwritten notes:
Myersville, Md.
Myersville, Md.

United States, Fred. Co. Md.

Myersville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04550

04547

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Monocacy Hall Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle E. Last Urban		4. DATE OF DEATH Month April Day 11 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21-1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Franklin Sherald		14. MOTHER'S MAIDEN NAME Margaret Graser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 217-12-1500	
17. INFORMANT Mrs. Kathryn E. Grove-100 E. 3rd. St. Frederick Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis with left hemiplegia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 24 19 62 to April 11 19 62 that (I) (we) last saw the deceased alive on April 11 19 62 and that death occurred at 7:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Henry V. Chase M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 4 E. Church St. Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 14-1962	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick-Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Dailey's Funeral Home-Frederick-Maryland		25a. REC'D BY REGISTRAR APR 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

Funeral Home - Frederick - Maryland

Apr. 11-1962 Mr. Oliver Cemetery

Frederick - Maryland

Henry V. Chase
Henry V. Chase

Apr. 11-62

74

Feb. 22 - April 11, 62

Charles H. Hunsicker

Frederick - Maryland
Frederick - Maryland

217-22-1500 Mrs. Kathryn E. Grove-100 E. 3rd. St. - Frederick

Frederick - Maryland

James Franklin Sherrill

Frederick - Maryland

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Monocacy Hall Nursing Home

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FOR STATE HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. (I)
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04551					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					04548				
1. PLACE OF DEATH e. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (rural) Buckeystown			c. LENGTH OF STAY IN 1b 55 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X (rural) Buckeystown									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt 4 Buckeystown, Fred, Co Md					d. STREET ADDRESS Rt 4 Buckeystown, Fred, Co. Md					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Dora Lottie Whimbs			First Middle Last		4. DATE OF DEATH Month Day Year 4 23 19 62									
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-4-1868		9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY *****			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Edward Bowie					14. MOTHER'S MAIDEN NAME Mary Spencer									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No *****			16. SOCIAL SECURITY NO. None		17. INFORMANT Mary W. Page Bolivar, West Va.					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arterio-Sclerosis (c) DUE TO 5 years +										INTERVAL BETWEEN ONSET AND DEATH 20 minutes				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE <i>B.O. Thomas</i>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 4-23-62 Fred, Md				
EXAMINER'S NAME (Type) B.O. Thomas					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Professional Bldg				
Address (Street, city, town, or county)														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 4-26-62		22c. NAME OF CEMETERY OR CREMATORY Carrollton Manor			22d. LOCATION (City, town, or country) (State) Frederick, Co Md						
23. FUNERAL DIRECTOR C.E. Hicks, 111					ADDRESS Frederick, Md			24a. REC'D BY REGISTRAR DATE APR 30 '62		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>				

04342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04342

IN THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

04552										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										04549																			
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick										c. LENGTH OF STAY IN 1b Lifetime										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital										d. STREET ADDRESS 404 West 2nd. St.										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Harry Middle Webster Last Whitehill										4. DATE OF DEATH Month April Day 29 Year 1962																													
5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			B. DATE OF BIRTH July 9-1899			9. AGE (In years last birthday) 62 yrs.			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HRS. Months Days Hours Min.																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman										10b. KIND OF BUSINESS OR INDUSTRY Wholesale tobacco										11. BIRTHPLACE (State or foreign country) Maryland										12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Reese Whitehill										14. MOTHER'S MAIDEN NAME Norine Douty																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes										16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWar 1 214-10-1305										17. INFORMANT Mrs. Irlene S. Whitehill-404 W. 2nd. St.-										Address Frederick-Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 7-8 days 8-10 yrs.																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 10/23 1960 to 4/29 1962, that (I) (we) last saw the deceased alive on 4/29 1962 and that death occurred at 2 P.M. from the causes and on the date stated above.																																							
22a. SIGNATURE Richard C. Reynolds M.D.										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED 3/1/62																			
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds										22d. ADDRESS Toll House Ave.-Frederick-Md.																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF May 2-1962										23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery										23d. LOCATION (City, town, or county) Frederick-Md. (State)									
24. FUNERAL DIRECTOR'S SIGNATURE Bailey's Funeral Home- Frederick- Md.										ADDRESS										25a. REC'D BY REGISTRAR DATE MAY 2 '62										25b. REGISTRAR'S SIGNATURE Arthur S. Thomas									

LITERATURE

May 3-1965

McGraw-Hill Company

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Dr. Richard C. Reynolds

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Mr. & Mrs. J. W. Smith - 100 N. 1st St.

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Journal of Management Education

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04553

CERTIFICATE OF DEATH

04550

Item 9 Film 9312 5/1/62 mb

1. PLACE OF DEATH a. COUNTY FREDERICK b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FREDERICK c. LENGTH OF STAY IN TB MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FREDERICK CITY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DUNDALK d. STREET ADDRESS 2900 LIBERTY PKWY. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PEARL M. WHITLOCK First Middle Last 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5/7/91 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH 4/22/62 19 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 10b. KIND OF BUSINESS OR INDUSTRY Homemaker 11. BIRTHPLACE (County & State, or foreign country) Ind. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Lingenfelter 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. Wm. E. Whitlock 17. INFORMANT Address Wm. E. Whitlock		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Coronary Thrombosis with complete left bundle branch block 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan. 4 , 19 57 to Apr. 12 , 19 62 that (I) (we) last saw the deceased alive on 4-12 , 19 62 , and that death occurred at M , from the causes and on the date stated above. 22a. SIGNATURE Lester Lebo 22b. DATE SIGNED 4/25/62 22c. PHYSICIAN'S NAME (Type) LESTER LEBE 22d. ADDRESS 1801 Eutaw Pl, Balto 17	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4/27/62 23c. NAME OF CEMETERY OR CREMATORY Good Shepherd 23d. LOCATION (City, town or county) (State) Howard Co Ind.		24. FUNERAL DIRECTOR'S SIGNATURE Macduff & Son ADDRESS 301 Frederick Ave 25. REC'D BY REGISTRAR APR 27 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

Doc 60

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04554

04551

1. PLACE OF BIRTH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 East 8th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Etta S. Whitmore		4. DATE OF DEATH Month April Day 15 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1873
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Libertytown, Fred. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas P. Whitmore		14. MOTHER'S MAIDEN NAME Mary Carr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Elwood T. Whitmore		Address Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) GENERALIZED ARTERIOSCLEROSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/8 1960 , to 5/20 1961 , that (I) (we) last saw the deceased alive on 5/20 1961 , and that death occurred at 6^{PM} M, from the causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds, M.D.		22b. DATE SIGNED 4-16-1962	
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds		22d. ADDRESS M.D. 9 East Church Street Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-18-1962	
23c. NAME OF CEMETERY OR CREMATORY Fairmont Cemetery		23d. LOCATION (City, town, or county) (State) Libertytown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey & Son		25a. REC'D BY REGISTRAR APR 18 62	
25b. REGISTRAR'S SIGNATURE Robert E. Bailey		25c. DATE APR 18 62	

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Dr. Richard C. Reynolds M.D. 9 East Church Street Portland, Me.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04555

CERTIFICATE OF DEATH

04552

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN b. Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 351 West Patrick Street		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 351 West Patrick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RHODA Middle CATHERINE Last YINGER		4. DATE OF DEATH Month April Day 4 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 March 1872
9. AGE (In years at birthday) 90		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Isiah Rice	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Pauline Y. Boyer (Same as item #1)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anger's Heart Failure DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 Day INTERVAL BETWEEN ONSET AND DEATH 1 year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1957 , to Apr 4, 1962 , that (I) (we) last saw the deceased alive on Apr 4, 1962 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas E. Stone M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5 Apr 1962	
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.		22d. ADDRESS 4 W. 3rd St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-7-62	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR APR 9 '62 25b. REGISTRAR'S SIGNATURE Arthur S. House	



04558

04558

Frederick

Frederick

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Frederick

351 West Jackson Street

351 West Jackson Street

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Mr. Charles F. Beyer (Owner of land)

None

None

Handwritten notes:
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Thomas M. Beyer, M. D.

Dr. F. J. Beyer, M. D.

1-1-02

Home Office

Frederick, Maryland

W. M. Robinson, Jr., Frederick, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled out. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit.

VS A15 (4)
15M 9/55

04556

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G31 1/23/62 mb

CERTIFICATE OF DEATH

Reg. Dist. No. 04553

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown / Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley View Nursing Home				d. STREET ADDRESS RFD #5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arba Middle Walter Last Younkins				4. DATE OF DEATH Month 4 Day 12 Year 1962			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/1881	
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) building painter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Martin L. Younkings				14. MOTHER'S MAIDEN NAME Caroline Koogle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Nursing Home Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of urinary Bladder 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to April 12 , 19 62 , that I last saw the deceased alive on April 10 , 19 62 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middletown DATE SIGNED 4-13-62							
ACTUAL SIGNATURE Dr. J. Elmer Harp M.D.				DATE SIGNED 4-13-62			
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp				Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/14/1962		22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE APR 16 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04554

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 502 East Patrick Street					d. STREET ADDRESS 502 East Patrick Street				
3. NAME OF DECEASED (Type or print) First GLEN Middle JOSHUA Last ZIMMERMAN					4. DATE OF DEATH Month April Day 28 Year 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 July 1891		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk		10b. KIND OF BUSINESS OR INDUSTRY Candy Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Franklin Zimmerman					14. MOTHER'S MAIDEN NAME Mary J. Stone				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 217-10-0635		17. INFORMANT Address Mrs. Lorraine W. Zimmerman (Same as item #1)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. 5 Yrs-Plus
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE B. O. Thomas		M.D. B. O. Thomas, M. D.		DATE SIGNED 30 Apr 1962					
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		Address (Street, city, town, or county) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-62		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or country) (State) Frederick, Maryland			
23. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland					24a. REC'D BY REGISTRAR DATE MAY 3 '62		24b. REGISTRAR'S SIGNATURE Orlando L. Thomas		

MEDICAL CERTIFICATION

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